

Please see instructions on back.

Iowa Department of Human Services

Child Care Provider Claim

1. Agreement No.: _____
2. Billing Period _____ - _____ - _____ thru _____ - _____ - _____
Enter the time period you are billing for. Month Day Year Month Day Year
3. Provider Name: _____
(Please print or type)
4. Provider Address: _____
5. Check if new address: ☐
6. City and State: _____ 7. Zip: _____
8. I certify that I provided services on the dates shown to the children listed below.
9. Choose type: ☐ Regular ☐ Protective

**Provider's
Signature**

Date

	10. Case Number	11. Child's Name Last First M.	12. If new, date service began	13. Service Code	14. Unit Cost	15. No. of Units	16. Total Cost	17. Co- Pay	18. Net Cost	For Local Office Use Only
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
19. TOTALS										

For DHS Use Only:

DHS Approval Signature: _____ Date: _____ Claim Number: _____
Date Returned to Provider: _____ Date Corrected Claim Received: _____

Instructions

The Child Care Provider Claim is used to bill the Department of Human Services (DHS) for payment. Before you start, please read the instructions below. You will need a copy of the Notice of Decision for each family and your Child Care Assistance (CCA) Provider Agreement to complete the claim.

1. **Agreement Number:** Enter the 7-digit number from the top, right corner of the CCA Provider Agreement. This can also be found on Page 4 of the Provider Agreement.
2. **Billing Period:** Enter the beginning and ending dates of the billing period. Please include the month, date, and year. For example, enter: 07-01-07 thru 07-31-07. This should match the dates listed on the attendance sheet.
3. **Provider Name:** Enter the name exactly as it appears on your CCA Provider Agreement.
4. **Provider Address:** Enter your current address.
5. **Check if new address:** Check the box if you have a new mailing address.
6. **City and State:** Enter your city and state.
7. **Zip:** Enter your zip code.
8. **Provider's Signature:** Your signature (must be in ink).
9. **Choose type:** Regular is child care for work, school, medical incapacity, or job search. Protective is child care that has been authorized by a DHS social worker. This information can be found on Page 1 of the family's Notice of Decision.
10. **Case Number:** See the family's Notice of Decision for case numbers, which are located on the top, right corner. Example: 999999-99-99-9.
11. **Child's Name:** Enter the child's last and first name and middle initial exactly as it appears on Page 1 of the Notice of Decision.
12. **If new, date service began:** If the child started receiving services during the period you are billing for, enter the date the service began. This information can be found on Page 1 of the family's Notice of Decision.
13. **Service Code:** See the CCA Provider Agreement on Page 4. The number is four digits.
14. **Unit Cost:** Enter the amount that you are being paid for each unit. See the rate section on Page 4 of the CCA Provider Agreement. A unit is any amount of time up to and including 5 hours in a 24-hour day. More than 5 up to 10 hours in a 24-hour day is 2 units.
15. **No. of Units:** Enter the total number of units you actually cared for the child during the billing period. You will use the number of units listed on the attendance sheet.
16. **Total Cost:** Multiply the unit cost (#14) by the number of units (#15). Put the answer here.
17. **Co-Pay:** This is the fee the parent pays to you. See the bullet on the Notice of Decision about fees. You will collect this amount from the parent and DHS will pay the rest of the bill. Multiply the unit fee on the Notice of Decision by the number of units you are billing for. Write the answer here. **This is a family fee, which means if you care for several children in the same family, you will collect a fee only for the child with the greatest number of units.**
18. **Net Cost:** Subtract the co-pay (#17) amount from the total cost (#16). This is the amount you will bill DHS.
19. **Totals:** Total the columns for total cost, co-pays and net cost.

If billing for daily/weekly units that are greater than what is approved on the Notice of Decision for the child, write a note on the attendance sheets to explain why.

Please attach attendance sheets to the claim.